PEDIATRIC SEASONAL FLU

VACCINE ADMINISTRATION
RECORD OF PARENT/GUARDIAN OR RECIPIENT SIGNATURE

I have been given a copy and have read, or had explained to me, the information in the "Vaccine Information Statement(s)" or the "Important Information Statement(s) for the disease(s) and vaccine(s) checked below. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and the risks of the vaccine(s) requested and ask that the vaccine(s) checked below be given to me or to the person named below for whom I am authorized to make this request.

Confidential Information:

Last Name:	First Name:	Middle Name:	DOB:	Age:	Gender: ○ Male ○ Female
Physician Name:	Medicaid #:	County of Residence:	Birth State:	Race:	Hispanic Origin: ○ YES ○ NO
Address:	City:	State:	Zip:	Home Phone: ( )	
Guardian 1 Last Name:	Guardian 1 First Name:	Guardian 1 Middle Name:	Mothers Maiden Name:	Work Phone: ( )	
Guardian 2 Last Name:	Guardian 2 First Name:				

I agree to allow information about all vaccinations given to me or to the person for whom I am authorized to consent, to be released to school and/or medical care providers to avoid the administration of unnecessary vaccinations and to ascertain immunization status. ☐ YES ☐ NO

Signature of person to recieve vaccine or person authorized to make request

_____
Signature

YES OR NO 1. Is the child sick today?

YES OR NO 2. Is the child allergic to eggs (or thimerosal?)

YES OR NO 3. Has the child ever had a serious reaction to a flu shot?

YES OR NO 4. Has the child ever had Guillian-Barre Syndrome?

☐ **Medicaid** ☐ **No Insurance** ☐ **Insurance does not pay** ☐ **Insurance Cap met** ☐ **Insurance Full coverage**

For Clinic use Only Clinic Name: **Bartholomew County Health Department**

VFC

Sanofi: 6 to 35 mos.	Sanofi: 36 mos. To 18 yrs.		MedImmune
U4482BA	UH712AA	UH7121AB	MIST AH2140

PRIVATE

Sanofi: 6 to 35 mos.	Sanofi: 36 mos. To 18 yrs.	MedImmune
U4488EA	U4481CB	MIST AH2139

Date Vaccinated _____ ☐RAIM ☐RLIM ☐LAIM ☐LLIM

Given by:_____ Registered Nurse